KENTUCKY BOARD OF CERTIFICATION OF ALCOHOL AND DRUG COUNSELORS

PO BOX 1360
FRANKFORT, KY 40602
(502) 564-3296 ext. 222
http://adc.ky.gov

Reference 201 KAR 35:020

APPLICATION FOR CERTIFICATION

INFORMATION SHEET / CHECKLIST

1. ☐ 18 years of age or older.
2. ☐ Section 1 of application completed and signed.
3. ☐ Section 2, 3, and 4 of the application completed; this relates to your education, your professional experience working with alcohol or drug dependant persons, three hundred (300) hours of direct supervision by a certified alcohol and drug counselor who has at least two (2) years of post certification experience.
4. ☐ Request an official transcript conferring your highest degree be sent from the registrar of the institution directly to the board (issued to student, and copies of transcripts are not acceptable.)
5. ☐ Section 5 of the application completed; this relates to your training experience totaling your hours. Have your supervisor(s) complete section 5 which relates to your supervision; Note: Section 5 must be submitted by each supervisor for qualifying experience.
6. ☐ Two (2) letters of reference from certified alcohol and drug counselors.
7. ☐ Case presentation using form included in the application packets and must be submitted with your application.
8. ☐ Pass the written examination that has been approved by the International Certification Reciprocity Consortium on Alcoholism and Drug Abuse.
9. ☐ Check or money order made payable to the Kentucky State Treasurer in the amount of $200.00.

DO NOT SEND CASH

NOTE: The application form and all supporting documentation required, as listed above, must be reviewed and approved by the board in order for the applicant to sit for the written examination. Incomplete applications will not be reviewed by the board. It is the applicant's responsibility to make certain that all materials have been received by the board office. You may contact the office to check on the status of your applications materials.

Following board review, you will be notified in writing of your results. Results will not be given over the phone.

WRITTEN EXAM SCHEDULE

Exam Date	**Filing Deadline**
March 7, 2014(Friday)	January 1, 2014
June 13, 2014 (Friday)	April 1, 2014
September 12, 2014 (Friday)	July 1, 2014
December 12, 2014 (Friday)	October 1, 2014

FEE SCHEDULE

Application Fee	$ 50.00
Re-filing Application Fee	20.00
Written Exam	$150.00
Initial Certification Fee	$200.00

APPLICATION INSTRUCTIONS

1. You must print the form, and apply your handwritten signature. Application forms submitted without the appropriate signatures will be returned.
2. Please attach the application fee of $50.00 that is non-refundable. Please make all checks or money orders payable to the Kentucky State Treasurer. DO NOT SEND CASH.
3. The completed application may be submitted to the Kentucky Board of Certification of Alcohol and Drug Counselors either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by delivery to 911 Leawood Drive, Frankfort, Kentucky 40601.
4. Please submit $150.00 Written Exam fee once application is approved. Please make all checks or money orders payable to the Kentucky State Treasurer. DO NOT SEND CASH.

NOTE: Upon receipt of certification, it is your responsibility to keep the Board Office informed of any address Change. **Please do not rely on forwarding services of the United States Postal Service.**

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APPLICATION FOR CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR
Section 1 Applicant Information

Certificate Number: _____
Date of Issue: _____
☐

Name (This is the way your name will appear on your certificate)

Address

Address

City State Zip Code

Home Telephone Number

Home E-mail Address

Social Security Number

Present Place of Employment

Address

Address

City State Zip Code

Present Place of Employment Telephone Number

Present Place of Employment Email Address

1. Have you had a certification/license in Kentucky or any other state that has ever been suspended or revoked? ☐ Yes ☐ No.
   If yes, give details: _____

2. Have you been convicted of a felony or pled guilty, including an Alford plea (other than minor traffic violations) under the laws of the United States in the last 3 years?
   ☐ Yes ☐ No. If yes, what offense? _____
   (Send Supporting Documentation)

3. Are you credentialed as an alcohol and drug counselor in any other state? ☐ Yes ☐ No.
   Where? _____ Title of Credential: _____

4. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position, from any professional training program, or from the program of any university? ☐ Yes ☐ No (If yes, send supporting documentation)

5. Have you ever been sanctioned by the Kentucky Certification Board of Chemical Dependency Professional or by any other professional associations for ethical misconduct? ☐ Yes ☐ No. (If yes, send supporting documentation)

6. Are you currently serving in the military? ☐ Yes ☐ No.

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AFFIDAVIT

I do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the board.

Applicant's Signature: _____ _____

(Sign your name – Do not print or type) Date

SECTION 2 (EDUCATION)

(Request an official transcript conferring highest degree be sent from registrar of institution)

		Dates Attended		Date of Graduation			
School	Name and Location	From	To	Month	Year	Number of Hours or	Degrees Obtained
Baccalaureate							
Master's							
Doctoral							

SECTION 3 (EXPERIENCE)

You must have completed 6000 hours of board-approved experience working with alcohol or drug dependant persons. Experience: A minimum of 3 years full-time supervised experience in alcohol and drug counseling. For those applicants whose caseload is less than 100 percent with alcohol and drug counseling must be documented (i.e., 50 percent workload devoted to alcohol and drug counseling, 6 years experience: 75 percent devoted to alcohol and drug counseling, 4 ½ years). Pursuant to 201 KAR 35:070 Section 3: You may substitute work experience for a degree in a related field. A master's degree or higher may be substituted for three thousand (3,000) hours of work experience, A masters degree or higher in a related field, with a specialization in addictions or drug and alcohol counseling may be substituted for 4,000 hours of work experience. A bachelor's degree in a related field may be substituted for two thousand (2,000) hours of work experience.

Work Substitution Request

Name of College or University: _____

Degree Earned: _____

Number of Work Substitution Hours requested: _____

*Official transcripts must be sent from the institution directly to the board

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Employed: From Mo. Yr. to Mo. Yr. Title or Position: _____ Name of Employer: _____ Address of Employer: _____	Describe your Duties as they relate to the 12 core functions:
Name of Clinical Supervisor: _____ Credentials of Clinical Supervisor: _____	Total Number of ATODA Work Hours: _____

Employed: From Mo. Yr. to Mo. Yr. Title or Position: _____ Name of Employer: _____ Address of Employe : _____	Describe your Duties as they relate to the 12 core functions:
Name of Clinical Supervisor: _____ Credentials of Clinical Supervisor: _____	Total Number of ATODA Work Hours: _____

Employed: From Mo. Yr. to Mo. Yr. Title or Position: _____ Name of Employer: _____ Address of Employer: _____	Describe your Duties as they relate to the 12 core functions:
Name of Clinical Supervisor: _____ Credentials of Clinical Supervisor: _____	Total Number of ATODA Work Hours: _____

SECTION 4 (VERIFICATION OF CLINICAL SUPERVISION / PRACTICUM / ON THE JOB TRAINING)
(Completed by Applicant and Signed by Supervisor)

A minimum of 300 hours of direct supervision from a certified alcohol and drug counselor who has had at least two (2) years of post-certification experience is required (includes activities designed to provide training in specific counselor functions). These activities are monitored by supervisory personnel who provide timely positive and negative feedback to assist the counselor in the learning process. Please document the number of hours spent receiving this type of supervision and agency(s) where it occurred. Remember, you must be able to document a minimum of 10 hours face-to-face clinical supervision in each Core Function and a total of 300 clock hours of supervision.

FUNCTIONS	**Dates/Hours**	**SUPERVISOR'S SIGNATURE**	**METHOD OF SUPERVISION (i.e. face to face, video, observation, telephone)**
1. Screening The process by which a client is determined appropriate and eligible for admission to a particular program. Total of Hours:			
2. Client Intake The process of collecting client information at the beginning of treatment that is used in assessment of a client for treatment. Total of Hours:			
3. Client Orientation Individual or group sessions to familiarize clients with program services, expectations, and goals. Total of Hours:			
4. Client Assessment The process by which a counselor evaluates the intake information collected in order to determine the appropriate services. This includes, Substance Abuse Evaluation, knowledge and application of the major theories and stages of addiction and the symptomatology of substance is assessing a client's use of chemical substances. Total of Hours			
5. Treatment Planning Defining areas of problems and needs, establishing long and short-term goals, and developing appropriate tools for reaching these goals. Total of Hours:			

6. (a) Individual Counseling A one-to-one counselor/client process for the purpose of assessing a client's problems and facilitating appropriate changes Total of Hours:			

6. (b) Group Counseling A process involving clients for the purpose of jointly exploring the client's problems and facilitating appropriate changes. Total of Hours:			
6. (c) Family Counseling A process of exploring the dynamics of the family system and facilitating appropriate changes. Total of Hours:			
7. Case Management Activities which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contracts. Total of Hours:			
8. Crisis Intervention Those services which respond to an alcohol and/or drug abuse's needs during acute emotional and/or physical distress. Total of Hours:			
9. Client Education Seminars or workshops which have the major goal of increasing the clients knowledge and patterns of problematic behavior. Total of Hours			
10. Referral Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to utilize the support systems and community resources available. Total of Hours:			
11. Reports and Record Keeping			

Charting the results of the assessment and treatment plan: writing reports, progress notes, discharge summaries and other client related data. This includes written communications and other professionals regarding a client's needs and treatment planning.			
Total of Hours:			
12. Consultation Relating with counselors and other professionals in regard to client treatment (services) to assure comprehensive, quality care for the client.			
Total of Hours:			

Combined Total of Hours: _____

SECTION 5 (SUPERVISION EVALUATION)
(Completed by each Supervisor)

This form must be entirely completed by each supervisor of qualifying experience. Please pay special attention to the number of hours of direct clinical supervision and percentage of applicant's time allotted to chemical dependency clients.

Applicant's Name: _____

Applicant's Address: _____

_____

Supervisor: _____ Title: _____

Current Address: _____

Date of Issue of Certification: _____ Supervisor's Day Telephone Number: ____/____/____

Program or agency where you supervised the applicant: _____

I have supervised the applicant's work from _____ (Date) to _____ (Date), which includes approximately _____ hours of face to face clinical supervision per month for a total of _____ hours.

The approximate percentage of his/her time spent in delivery of services to substance abuse clients: _____%

PERSONAL ATTRIBUTES:

Evaluate the applicant as you observe(d) him/her in the following areas of interpersonal relationship with clients: (Please use appropriate number as indicated on scale.)

1 / Weak	2 / Fair	3 / Average	4 / Above Average	5 / Superior	6 / NA

_____ A. Respect for client.

_____ B. Care and concern for client.

_____ C. Genuineness with client.

_____ D. Empathy with client.

_____ E. Flexibility with client.

_____ F. Clinical Judgment with client.

_____ G. Spontaneity with client.

_____ H. Capacity for confrontation with client.

_____ I. Capacity for appropriate self-disclosure.

_____ J. Sense of immediacy.

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_____ K. Concreteness.

AREAS OF COMPETENCY

The following items are representative of the skills needed by a certified alcohol and drug counselor in the core functions. Evaluate the applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most nearly descriptive of the applicant's demonstrated skills using the scales given.

_____ A. Screening – (Demonstrated competency in determining appropriateness for admission to a program.)

_____ B. Intake – (Demonstrated competency in client intake process.)

_____ C. Client Orientation – (Demonstrated competency in client orientation and motivation.

_____ D. Assessment – (Demonstrated competency in the use of psycho-social tools for assessing the intensity and and extent of a client's problem with chemical dependency.

_____ E. Treatment Planning – (Demonstrated competency in establishing treatment goals and plan for client.

_____ F. Counseling – (Demonstrated competency in individual counseling.)

_____ G. Counseling – (Demonstrated competency in group counseling.)

_____ H. Counseling – (Demonstrated competency in counseling of the family of the client and significant others.)

_____ I. Case Management – (Demonstrated competency in coordinating multiple treatment activities and support systems for the client.)

_____ J. Crisis Intervention – (Demonstrated competency in crisis intervention.)

_____ K. Client Education – (Demonstrated competency in didactic presentations.)

_____ L. Referral – (Demonstrated competency in identifying the needs of the client that cannot be met by the counselor and assisting the client to utilize other agency or community resources available.

_____ M. Reports / Record Keeping. – (Demonstrated competency in ability to relate to our own and other professionals to assure comprehensive care for the client.

PROFESSIONAL AND ETHICAL CONDUCT:

1. Employment of fraud or deception in applying for a certificate: ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

2. Practice of Alcohol and Drug Counseling under a false or assumed name or the impersonation of another counselor of a like or different name. ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

3. Habitual abuse of any mood-altering chemical substance to such an extent as to interfere consistently with the competent performance of his/her duties. ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

4. Misrepresentation of one's professional credentials: ☐ Yes ☐ No. If yes, please comment:
   Comment: _____
5. Failure to adhere to KRS 309.080 to 309.089: ☐ Yes ☐ No. If yes, please comment:

Comment: _____

_____

Describe what you believe to be significant strengths and / or deficiencies of the applicant:

_____

I recommend _____ for certification as an Alcohol and Drug Counselor.
Applicant's Name

I do not recommend _____ for certification as an Alcohol and Drug Counselor.
Applicant's Name

Signature: _____ Title: _____

Current Address: _____

_____

Date Signed: _____

SECTION 6 (TRAINING RESUME)
COURSE / CLASSROOM EXPERIENCE
(Completed by Applicant)

A minimum of 270 classroom hours of board-approved ATODA counseling related curriculum including a minimum of 6 hours of ethics training and 2 hours of HIV training required. KRS 309.083(5)

TITLE OF COURSE, INSERVICE, PROGRAM ETC.	APPROX. DATES OF ATTENDANCE	AGENCY OR INSTITUTION OFFERING TRAINING	NO . OF ACTUAL TRAINING HOURS	IDENTIFY, BY NUMBER, CORE FUNCTION(S) FULFILLED BY COURSE OR PROGRAM EXAMPLE: 1=SCREENING 2=Intake	INDICATE: A – ALCOHOL D – DRUGS C – COUNSELING E – ETHICS H – HIV O – OTHER
		Total:			

If necessary, copy this form for additional pages.

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DIRECTIONS FOR PREPARING CASE PRESENTATION

Your Case Presentation must be typed and do not use abbreviations.

1. Use an actual client from your case files, one who has completed treatment or is no longer obtaining your services. Use a fictitious name for the client.
2. Complete the demographics information on the client.
3. Provide the information for items A through K as outlined below and continuing on the following page.
4. Sign the Counselor's Statement on the cover sheet.
5. Give the completed case presentation to your supervisor for his/ her review and signature. (on the cover sheet.)

OUTLINE FOR PREPARING CASE PRESENTATION:

A. Substance Abuse History

1. Substances used
2. Frequency
3. Progression
4. Severity / Amount used
5. Onset – When started
6. Primary substance
7. Route of administration
8. Effects – blackouts, tremors, tolerance, DT's, seizures, other medical complications (some of these can be included in the Physical History Section.)

B. Psychological Functioning

1. Mental Status (Oriented, hallucinations, delusions, suicidal, homicidal, judgment, insight to include both past and present.

C. Educational /Vocational/Financial

1. Educational and work history.
2. Educational level.
3. Disciplinary action (at school or work)
4. Reasons for termination
5. Current and past financial status

D. Legal History (Associated with, or not associated with, mood altering chemicals)

1. Charges, arrests, convictions
2. Current status
3. Pending

E. Social History

1. Parents
2. Siblings / rank
3. Psychological functioning in family
4. Substance use in family
5. History of social functioning from childhood to present
6. Family functioning including physical, sexual and emotional abuse
7. Relationship history
8. Children

F. Physical History

1. Both alcohol and drug, non-alcohol and drug problems.
2. Past and present major medical problems – i.e., disabilities, pregnancy, and related issues, STD, alcohol and drug related problems.

G. Treatment History

1. Both alcohol and drug and psychological history.

H. Assessment

1. Identifying and evaluating an individual's strengths, weaknesses, problems and needs for development of the treatment plan.

I. Treatment Plan

1. Identifying and ranking problems needing resolution; establishing agreed upon immediate and long term goals; deciding on a treatment process and the resources to be utilized.

J. Course of Treatment

1. Describe the counseling approaches you used, your rationale for their use and any revision you made based on the client's unique problems and responses to treatment.

REQUIRED FORM

CASE PRESENTATION

BY

_____

COUNSELORS NAME

COUNSELOR'S STATEMENT

I hereby certify that I prepared this case presentation and that it represents an actual case of mine.

I understand that the audio tape of the case presentation interview and written-case presentation will be the property of the Kentucky Board of Certification of Alcohol and Drug Counselors upon submission of the materials for review by the Board.

I also understand that this material may be reviewed by the Board and its designated agents for evaluation and research purposes.

Signature: _____

Date: _____

SUPERVISOR'S STATEMENT

I hereby certify that I have read this case presentation, that it represents an actual case of the applicant and that to the best of my knowledge, it was prepared by him/her.

Name: _____

Title: _____

Name of Agency: _____

Signature: _____

Date: _____

REQUIRED FORM

DEMOGRAPHIC INFORMATION ON ACTUAL CLIENT

Fictional Name: _____

Age at Admission _____ Race: _____ Sex: _____ Marital Status: _____

Employment: _____

Referral Source: _____

Current Legal Status: _____

Admission Date: _____ Discharge Date: _____

Treatment Setting and Modality: _____

_____

_____